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Testimony of the
American Hospital Association
before the
Health Subcommittee
of the
Energy and Commerce Committee
of the
U.S. House of Representatives
on

"Keeping the Promise: Site-of-Service Medicare Payment Reforms"

May 21, 2014

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,200 inpatient rehabilitation facilities (IRFs), 288 long-term care hospitals (LTCHs) and 850 hospital-based skilled nursing facilities (SNFs), thank you for the opportunity to testify today and provide the hospital perspective on site-of-service payment proposals.

My name is Reginald Coopwood, M.D., and I am the president and CEO of Regional One Health located in Memphis, Tennessee. Our health system, which serves a three-state area, includes a nationally acclaimed Level 1 trauma center, a Level III neonatal intensive care unit, the only American Burn Association certified burn center in our three-state region and a high-risk obstetrical referral center. Annually there are more than 100,000 outpatient visits to our health system.

The AHA and the hospital field are extremely concerned about site-neutral payment proposals that would pay hospitals at the payment rates of facilities with lesser clinical capabilities. Americans rely heavily on hospitals to provide 24/7 access to emergency care for all patients, to serve as a safety-net provider for vulnerable populations, and to respond to every conceivable type of disaster. These roles are not explicitly funded; instead they are built into a hospital's overall cost structure and supported by revenues received from providing direct patient care across various settings. Therefore, the AHA urges Congress to reject site-neutral payment policies for hospital outpatient departments (HOPDs). Our detailed comments below explore these issues as well as post-acute care site-neutral payment proposals.

SITE-NEUTRAL PAYMENT PROPOSALS FOR HOPDS

Policymakers are considering a number of site-neutral payment proposals. They include capping HOPD payments for evaluation and management (E/M) services at a residual of the physician fee schedule (PFS) payment; capping HOPD payments for a specific set of 66 payment categories at a residual of the PFS; capping HOPD payments for 12 surgical procedures at the ambulatory surgical center (ASC) payment level; redistributing the payment for administration of chemotherapy services by raising payments to private practice oncology clinics; and reducing payments to HOPDs.

There are specific problems with each of these site-neutral payment proposals, which are discussed below, but the unifying issue is the proposals seek to pay less for specific treatments while expecting the hospitals will be able to continue to provide the same services at the current level. However, the Medicare Payment Advisory Commission (MedPAC) has found that HOPD Medicare margins are negative 11.2 percent, thus hospitals are already losing money providing these services to beneficiaries. In addition, hospitals are subject to significant regulatory and quality requirements, none of which would be lowered under the proposed payment reductions. Enacting the three main site-neutral payment proposals would result in HOPD Medicare margins of *negative 20 percent* – an alarming level that could force hospitals to curtail these services and threaten seniors' access to care (see Attachment A).

EVALUATION AND MANAGEMENT (E/M) SERVICES

A 2012 MedPAC recommendation would cap "total" payment for non-emergency department E/M services in HOPDs at the rate paid to physicians for providing the services in their private offices. However, in the 2014 outpatient prospective payment system (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) collapsed the 10 separate E/M codes for hospital outpatient clinic visits, and replaced them with one new code representing a single level of payment for all outpatient clinic visits. The previous clinic visit codes reflecting five levels of resource intensity and the distinction between new and established patients are no longer recognized in the outpatient PPS. The adoption of a single code for all hospital outpatient clinic visits means a one-to-one coding match no longer exists to implement MedPAC's recommendation. MedPAC has not revisited its recommendation or its impact analysis since CMS finalized the E/M code collapse policy.

MedPAC had estimated that this recommendation would reduce Medicare spending by $900 million per year and $9 billion over 10 years, by reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services.

Given CMS's sweeping changes to the coding structure for E/M hospital outpatient clinic visit services, it is unclear how Congress could enact MedPAC's ill-advised prior recommendation to equalize Medicare payment rates for E/M services between HOPDs and physician office settings. However, even if it is possible, the AHA strongly opposes such an approach because:

- Hospitals provide access to critical hospital-based services that are not otherwise available in the community and treat higher-severity patients;

- Hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity; and
- Hospitals have more comprehensive licensing, accreditation and regulatory requirements than physician offices.

Like the other site-neutral proposals, the E/M cuts would create even greater shortfalls in Medicare payments and would hamper hospital-physician care integration. Teaching and safety-net hospitals would be hardest hit by the proposed E/M cuts. While the overall cut to U.S. hospitals would be 2.8 percent, impact data from before CMS changed the E/M visit coding structure show that the impact for major teaching hospitals would be a 5.8 percent cut, and urban, public safety-net hospitals would face a 4.9 percent cut. Hospital-based clinics at teaching and safety-net hospitals provide services that are not otherwise available in the community to vulnerable patient populations. The costs in these hospital-based clinics are higher due to greater regulatory requirements, more medically complex and chronically ill patient populations, stand-by capacity costs related to offering emergency department and other services 24 hours a day, 365 days a year, and also the costs of unreimbursed "wrap-around" services.

An AHA analysis of Medicare data demonstrates that patient severity for E/M clinic visits, as measured using weighted hierarchical condition categories (HCC) scores, is nearly 24 percent higher in HOPDs than in physician offices. HOPDs serve a higher percentage of patients who are dually eligible for both Medicaid and Medicare than physician offices. HOPDs also serve a higher percentage of disabled patients.

66 AMBULATORY PAYMENT CLASSIFICATIONS

MedPAC has recommended broadening the application of its site-neutral payment policy for HOPD services to an additional 66 payment categories beyond its March 2012 recommendation to cut payment for 10 E/M services. Overall, the impact of these cuts would be very significant. MedPAC analysis shows that cuts to these services would decrease Medicare outpatient payments by 2.6 percent, or $1.1 billion per year. When combined with the E/M cuts already recommended by the commission, the site-neutral payment policies would impose deep cuts of $2 billion per year on routine outpatient services that are integral to the service mission of hospitals. Together, they would reduce Medicare outpatient payments by 5.5 percent, and reduce hospitals' Medicare outpatient margins from a negative 11.2 percent in 2011 to a negative 17.7 percent, all else being equal.

In its discussions regarding expansion of the site-neutral payment policy to additional ambulatory payment classifications (APCs), MedPAC considered whether the impact on hospitals would be lessened because hospitals employ many physicians practicing in HOPDs and, therefore, collect both the physician fee and the hospital facility fee. Supported by comments from MedPAC staff, some concluded that the hospital would not receive just the residual amount provided under MedPAC's site-neutral payment policy, but instead would be paid at least as much as a physician would receive under the Medicare PFS if the same service had been furnished in a physician's office.

The AHA disagrees. First, hospitals incur the costs of providing services whether or not the physician is employed. When the physician is employed, the hospital also must pay the

physician for his or her services. Second, only a minority of physicians are employed by hospitals. According to 2012 data from the American Medical Association and AHA, only 19 percent of physicians (excluding interns and residents) are employed by community hospitals. While the number of employed physicians is increasing for the reasons MedPAC cited in its March 2012 report, the increase is modest, only 6.5 percent between 2011 and 2012. Thus, in most circumstances, HOPD services are often furnished to beneficiaries by physicians who are not employed by the hospital. In these cases, if MedPAC's policy were implemented, the hospital's payment in full would be the residual amount provided under MedPAC's site-neutral payment policy.

Hospitals also disagree with an assertion made by some MedPAC commissioners and staff that it is common practice for hospitals to charge non-employed physicians for the use of hospital facilities while also billing Medicare directly for the hospital's facility fee. In the discussion, it was stated that hospitals had an opportunity to mitigate the decline in Medicare revenue from the commission's site-neutral payment policy by negotiating with the non-employed physician to split the total Medicare revenue from this.

Our understanding based on practices in the field and regulatory requirements is that in the case of non-employed physicians furnishing services in a HOPD, the physician bills for his or her professional services under the PFS, the hospital bills the facility fee under the hospital outpatient PPS, and there is no splitting of the physician's Medicare payment with the hospital. Splitting Medicare money as suggested would, at a minimum, be viewed as inappropriately double billing the facility fee. Additionally, law enforcement would, more likely, view the exchange as creating a high risk of abuse and lead to scrutiny under the Stark law and anti-kickback statute.

PAYMENT AMOUNTS SHOULD BE SET APPROPRIATELY

MedPAC's site-neutral recommendations have assumed that the Medicare PFS payment rate somehow reflects the correct rate to pay for outpatient services, when, in fact, it is difficult to determine how well Medicare PFS payment rates reflect the actual costs of specific services. It is fair to say that the differences in the payment rates for similar services across ambulatory settings are largely artifacts of the very different and complex methodologies that Congress enacted and that CMS implemented under the outpatient PPS and the PFS.

But outpatient PPS payments are generally based directly on hospital data – audited cost reports and claims data – and have been found by MedPAC to be significantly below cost. In contrast, physicians are not required to report their costs to Medicare; therefore, their costs cannot be compared to payment. Further, the PFS, and specifically its practice expense component, is based on voluntary responses to physician survey data held flat for years due to the cost of various physician payment "fixes." While the commission's discussion centered on whether, as a prudent purchaser, Medicare should refrain from paying more for a service in the HOPD setting than in the physician office setting, it is equally correct to question whether payment is adequate in the setting that is paid the lower amount.

HOPD PAYMENTS ARE THE RELEVANT COMPARISON

Most of the impact data presented at MedPAC meetings on site-neutral payment masked the extent of the cut to outpatient payments by presenting impact data based on overall Medicare payments – including inpatient and post-acute services – and not separately for outpatient payments. This presentation of impact runs counter to MedPAC's stated preference against cross-subsidies in payment, which would require looking at each payment system separately. The AHA believes that outpatient payments are the relevant base to consider when proposing outpatient cuts.

In looking at the impact across groups of hospitals, MedPAC presentations showed the combined impact of their site-neutral proposals would be higher for rural hospitals than other hospitals because of their greater dependence on outpatient revenue. However, this analysis was an *underestimate* because the focus on overall Medicare payments, not outpatient payments, likely masks the impact across hospital groups, as some hospital groups, including rural hospitals, generally provide a greater share of outpatient services.

HOSPITALS' EMERGENCY RESPONSE CAPACITY WOULD BE ENDANGERED

As stated above, hospitals are not physician offices and play a very different role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs and offering myriad other services to promote the health and well-being of the community. While many of these services also are offered by other health care providers, three are unique to hospitals:

- The provision of health care services, including specialized resources, 24 hours a day, seven days a week, 365 days a year;
- Caring for all patients who seek emergency care, regardless of ability to pay; and
- Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

These critical roles, while often taken for granted, represent an essential component of our nation's health and public safety infrastructure. Medicare beneficiaries and the public consistently express concern that cuts to hospital payments could mean fewer nurses and longer waits in emergency departments. The public also values the safety- net that hospitals provide and expects them to be open 24/7 to serve patients and their families.

Despite its importance, the standby role is not explicitly funded. Until a patient arrives with an emergency need, there is no payment for the staff and facility to be "at the ready." The AHA report, *Prepared to Care*[1], outlines the many elements of stand-by capacity that allow hospitals to respond to emergencies ranging from multi-vehicle car crashes to hurricanes and terrorist attacks. Recent events like Hurricane Sandy and the Boston Marathon bombings serve as a reminder that we, as a society, need this response capacity. Direct funding for this capacity is limited, and federal funding for the Hospital Preparedness Program declined by about 50 percent between fiscal year (FY) 2003 and 2014. While these funds are very much appreciated by

[1] Prepared to Care. available at http://www.aha.org/research/reports/preparedtocare.shtml

hospitals, they do not come close to meeting the costs of maintaining stand-by capacity and responding to disasters.

Please realize that without adequate, explicit funding, the stand-by role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices or any other type of provider.

HOPDS TREAT HIGHER-SEVERITY PATIENTS, FACE GREATER REGULATORY BURDENS
MedPAC staff has proposed a principle stating that patients should have access to settings that provide the most appropriate level of care. Hospitals agree. Hospitals want patients to receive care in the appropriate setting and note that community physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. We fear that with a significant reduction in payment, this may no longer be an option or fallback for community physicians.

In addition, hospitals face significantly higher regulatory requirements than physician offices. While many of these requirements help to ensure a higher level of quality and patient safety, they all impose additional costs. Attachment A highlights these regulatory differences, which include complying with the Emergency Medical Treatment and Active Labor Act (EMTALA), state hospital licensure requirements, the voluminous Medicare conditions of participation, and Medicare cost reporting requirements, among others. The higher costs associated with these regulations are legitimately reflected in higher Medicare reimbursement for services furnished in HOPDs compared to free-standing physician offices.

H.R. 2869, REPRESENTATIVE ROGERS CANCER TREATMENT PAY EQUALIZATION

This bill purports to ensure the availability of chemotherapy services by increasing the payments physicians receive to administer chemotherapy to cancer patients in private practice oncology clinics. However, the bill actually accomplishes this by cutting cancer treatment payments for HOPDs. The consequence of this legislation would be to limit access to chemotherapy services for many cancer patients who now receive their treatment in the outpatient setting of their community hospital.

Hospitals care for all patients who seek emergency care, regardless of their insurance status or ability to pay; maintain standby disaster readiness capacity in the event of a catastrophic occurrence; and treat patients who are too sick and require more complex services than those treated by private physician practices. In addition, HOPDs provide services to all Medicare and Medicaid patients. This is not the case for private physician practices.

Recent media reports detail how private practice oncology clinics are turning away Medicare patients[2]. Other reports highlight that it is the high cost of chemotherapy drugs that are the most

[2] Washington Post, April 3, 2013, "Cancer clinics are turning away thousands of Medicare patients. Blame the sequester." http://www.washingtonpost.com/blogs/wonkblog/wp/2013/04/03/cancer-clinics-are-turning-away-thousands-of-medicare-patients-blame-the-sequester/

significant driver of cancer treatment costs.[3] While HOPDs are seeing an increased number of patients, part of that is because private practice oncology clinics primarily serve those patients that are well insured and provide generous payments, and are declining to care for Medicare beneficiaries. In fact, analyses demonstrate that HOPDs serve patients with more complicated conditions or a higher case-mix, and do not refuse to treat Medicare and Medicaid patients.

Some people have incorrectly claimed that the 340B Drug Pricing Program, which provides discounted outpatient drug prices for safety-net providers, is a main driver of consolidation in the oncology field. Larger market forces have influenced independent oncology practices to merge with their community hospitals. Hospitals are strengthening ties to each other and physicians in an effort to respond to new global and fixed payment methodologies, as well as incentives for improved quality and efficiency, implementation of electronic health records and care that is more coordinated across the continuum. The 340B program is a vital part of the nation's safety net, gives patients better access to drugs they need for their care and helps hospitals enhance care capabilities by stretching scarce federal resources. As drug prices continue to rise,[4] this program becomes even more critical to vulnerable patients and communities.

As stated above, hospitals face many challenges to maintain the full panoply of services that the public expects to receive when they are sick and need care 24/7 – challenges that are not confronted by private practice oncology clinics. Increased demand for specialized services, staffing shortages, diminishing financial support from Medicare and Medicaid, capital expenses, increased accreditation requirements, and greater expectations for emergency preparedness are just a few of the challenges that hospitals are facing. H.R. 2869 would exacerbate the stress on hospitals and on cancer patients.

POST-ACUTE CARE SITE-NEUTRAL PAYMENT PROPOSALS

The AHA supports efforts to bring meaningful reforms to the post-acute care field to ensure patients' continued access to medically necessary services. The AHA approves of the cautious exploration of site-neutral payment policies that apply exclusively to patients who are clinically similar and can commonly receive post-acute care services in different post-acute care settings. However, to achieve true site-neutrality by paying equally for equal care, regardless of location, several crucial policy building blocks are necessary – some of which have not been fully developed.

Fair and equitable site-neutral payment must include equal Medicare reimbursement for like patients. If Medicare pays the same rate for patients treated in two settings, we must be confident that the same payment is applied to similar patients. This assurance is often difficult to

[3] Kaiser Health News, May 6, 2014, "Chemo Costs in U.S. Driven Higher By Shift."
http://capsules.kaiserhealthnews.org/index.php/2014/05/chemo-costs-in-u-s-driven-higher-by-shift-to-hospital-outpatient-facilities/

[4] Bloomberg , May 7, 2014, "Cancer Doctors Join Insurers in U.S. Drug-Cost Revolt."
http://www.bloomberg.com/news/2014-05-07/cancer-doctors-join-insurers-in-revolt-against-drug-costs.html

achieve given the high acuity and medical complexity of many beneficiaries. Further, different health settings admit largely distinct populations of patients and fill unique clinical roles. As the AHA discussed in an April 2014 letter to MedPAC (Attachment B), accurately matching patients by severity across care settings is very complex and requires more than grouping cross-site patients based on their principle diagnosis from the prior hospital stay. In addition, any post-acute care site-neutral proposal must be risk adjusted across settings. However, unfortunately, risk-adjustment efforts are still under development. Finally, any site-neutral payment proposal must provide a level playing field for Medicare regulations across the affected settings.

LTCH CRITERIA

In the Bipartisan Budget Act of 2013, Congress authorized stringent new criteria for long-term care hospital (LTCH) payment that will bring major reform to the LTCH field. The new criteria fall somewhere between the position that was promoted by AHA and the proposal that was being developed by CMS. Beginning in October 2015, LTCH cases that fail to meet these new criteria will be on a site-neutral basis, a far lower rate that is comparable to payments for general acute care hospitals. Approximately one out of two current LTCH cases will drop to the lower "site-neutral" payment rate. The new proposal is very complex, as recognized by CMS in its recent proposed payment regulation for FY 2015, and the AHA is closely studying the new LTCH-inpatient hospital site-neutral reform and will be sharing further feedback on this framework with members of Congress and CMS next month.

POST-ACUTE BUNDLED PAYMENT

CMS's bundling demonstration mandated by the Affordable Care Act will soon complete its first stage. Organizations participating in the demonstration are now preparing to move to the next stage, where they will begin to face financial risk. This is the only large-scale bundling project to date that includes post-acute care providers; therefore, this demonstration is an important opportunity to acquire a great deal of information on the clinical, operational and financial considerations of bundling post-acute services. Given the potential value of the early learning from these demonstrations, the AHA has urged Congress to allow and encourage the CMS Innovation Center to share these lessons with the broader provider community.

In addition to the Innovation Center's work, MedPAC and several members of Congress have developed other proposals to bundle post-acute care payments, including Representative David McKinley's Bundling and Coordinating Post-Acute Care Act (H.R. 4673). The AHA supports efforts to explore post-acute care only bundled payment models, in addition to other models. And it discourages endorsing a single bundling approach, which would be premature at this time.

IRF-SNF SITE NEUTRAL PAYMENTS FOR CERTAIN PROCEDURES

In March, MedPAC presented potential "site-neutral payment" approaches to reduce IRF rates to "SNF-like" levels for patients discharged from a general acute care hospital with one of three conditions (stroke, major joint replacement, and hip and femur fracture) who are clinically similar and commonly receive post-acute care services in both IRFs and SNFs. Paying for care in the IRF and SNF settings in a truly site-neutral manner is extremely complex and may be difficult to achieve. Nonetheless, the AHA supports the cautious exploration of a site-neutral payment policy that applies exclusively to patients who are clinically similar and can safely be treated in either setting. However, we are concerned that MedPAC has not targeted the

appropriate patients. Accurately matching patients across sites is difficult to accomplish and, as the AHA discussed in its April letter to MedPAC (Attachment B), requires more than grouping cross-site patients based on their principle diagnosis from the prior hospital stay.

CONCLUSION

The AHA and the hospital field are appreciative of your consideration of these issues and urge the Committee to exercise caution and not to propose any recommendations to Congress that would dramatically reduce payments to hospitals until a complete, transparent analysis and debate has occurred. Ensuring adequate payment for all services will allow hospitals to continue to ensure access to care for all patients.

In addition, the AHA supports the cautious exploration of post-acute site-neutral payment proposals to ensure patients' continued access to medically necessary services. However, to achieve true site-neutrality by paying equally for equal care, regardless of location, several crucial policy building blocks are necessary – and some of these policy components are still in development. Therefore, we have significant concerns regarding the viability of some post-acute site-neutral payment proposals.

Attachment A

American Hospital Association

Site-neutral Payment Proposals Threaten Access to Care

Americans rely heavily on hospitals to provide 24/7 access to care for all types of patients, to serve as a safety net provider for vulnerable populations, and to have the resources needed to respond to disasters. These roles are not explicitly funded; instead they are built into a hospital's overall cost structure and supported by revenues received from providing direct patient care. Hospitals are also subject to more comprehensive licensing, accreditation and regulatory requirements than other settings.

Yet some policymakers want to make total payment for a service provided in a hospital the same as when a service is provided in a physician office or ambulatory surgery center (ASC).

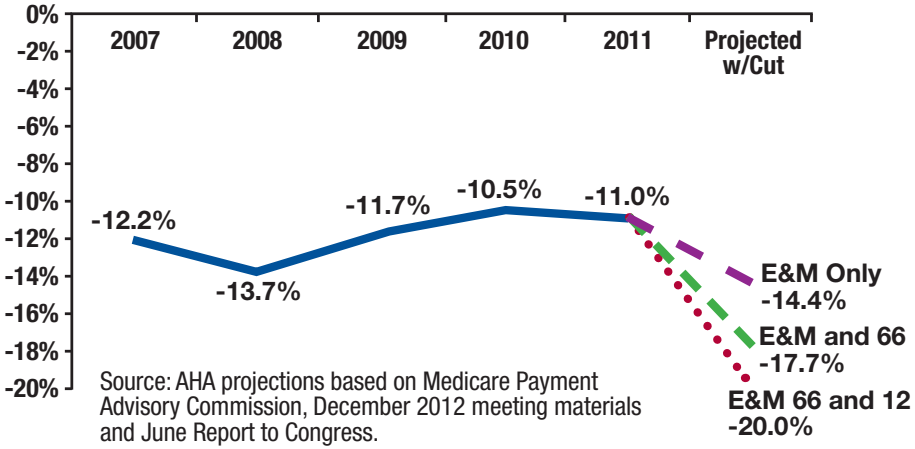
Lawmakers are considering three site-neutral payment changes that would result in lower payments to hospitals.

- Paying hospitals for evaluation and management (E/M) services in the hospital outpatient department (HOPD) setting at the physician fee schedule (PFS) amount
- Paying hospitals for 66 specified ambulatory payment classifications (APCs) at the PFS amount
- Capping hospital payments for 12 proposed APCs at the ASC rate

According to the Medicare Payment Advisory Commission's March 2013 report, Medicare margins are already negative 11 percent for outpatient services.

Implementing these policies would further erode HOPDs' Medicare margins, threatening access to care.

Medicare Margins for Hospital Outpatient Department Services, 2007-2011 and Projected with Proposed Cuts



Source: AHA projections based on Medicare Payment Advisory Commission, December 2012 meeting materials and June Report to Congress.

Regulatory Requirements/Roles	Hospital Outpatient Department	Ambulatory Surgery Center	Physician Office
24/7 Standby Capacity for ED Services	✔		
Back up for Complications Occurring in Other Settings	✔		
Disaster Preparedness and Response	✔		
EMTALA Requirements	✔		
Uncompensated Care/Safety Net	✔		
Teaching/Graduate Medical Education	✔		
Special Capabilities (burn, trauma, neonatal, psychiatric services, etc.)	✔		
Required Government Cost Reports	✔		
Equipment Redundancy Requirements	✔		
Stringent Building Codes (ventilation systems, hallway widths, ceiling heights, etc.)	✔		
Infection Control Program	✔	✔	
Quality Assurance Program	✔	✔	
Joint Commission Accreditation	✔	✔	
Life and Fire Safety Codes	✔	✔	✔
Malpractice Insurance	✔	✔	✔
Admin Staff/Billing	✔	✔	✔
Medical Supplies	✔	✔	✔
Nurses	✔	✔	✔
Space and Utilities	✔	✔	✔

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April 1, 2014

Glenn M. Hackbarth, J.D.
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Dear Mr. Hackbarth:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,200 inpatient rehabilitation facilities (IRFs) and 850 hospital-based skilled nursing facilities (SNFs), I write to respond to the Medicare Payment Advisory Commission's (MedPAC) March 6 presentation on site-neutral payment for IRFs and SNFs. During this presentation, MedPAC discussed potential "site-neutral payment" approaches to reduce IRF rates to "SNF-like" levels for patients discharged from a general acute care hospital with one of three conditions (stroke, major joint replacement, hip and femur fracture) who are clinically similar and commonly receive post-acute services in both IRFs and SNFs.

Paying for care in the IRF and SNF settings in a truly site-neutral manner is extremely complex and may be difficult to achieve. Nonetheless, the AHA supports the cautious exploration of a site-neutral payment policy that applies exclusively to patients who are clinically similar and can safely be treated in either setting. However, as outlined below, we are concerned that MedPAC has not targeted appropriate patients and urge the commission to refine its approach. As also outlined below, it is imperative that for services subject to IRF-SNF site-neutral payments, IRFs should face a level playing field with respect to regulatory requirements; that is, for services subject to site-neutral payments, the Medicare regulations requiring IRFs to provide hospital-level care must be removed.

SITE-NEUTRAL POLICY MUST TARGET CLINICALLY SIMILAR PATIENTS

When designing an IRF-SNF site-neutral payment policy, it is critical to ensure that the policy targets clinically similar patients. As discussed by MedPAC commissioners, achieving such an apples-to-apples comparison can be difficult due to the incompatible IRF and SNF patient classification systems. However, we have several suggestions that we believe would help ensure that MedPAC's policy targets clinically similar patients.

First, when comparing the mix of patients treated in more than one post-acute setting, MedPAC should use the most recent data available to ensure that any resulting policy recommendations reflect current post-acute referral and utilization patterns. The mix of IRF and SNF patients continues to shift due to changes in payment and coverage policies, yet MedPAC data charts from the March presentation used 2011 data rather than the most recent data available. Furthermore, both the presentation and the subsequent discussion cited the Centers for Medicare & Medicaid Services' (CMS) 2011 final report to Congress on the post-acute care payment reform demonstration, which is largely based on data collected from 2008 through 2010. We encourage MedPAC to update its analyses using 2012 data, and again with 2013 data when they become available this fall.

In addition, the AHA urges MedPAC to further refine its analysis to avoid solely relying on the prior acute care hospital discharge diagnosis to find similar IRF and SNF patients. The March presentation compared IRF and SNF data based on patients' discharge diagnosis from the prior stay in a general acute care hospital. However, relying solely on discharge diagnosis to classify patients for the purpose of comparing clinical characteristics has widely recognized limitations because a patient's prior hospital diagnosis is often unrelated to the patient's post-acute diagnosis, which addresses a different recuperative stage in the episode of care. For example, MedPAC estimated that 25 percent of IRF cases have one of the three targeted conditions based on IRF claims data, but these conditions represent only 0.8 percent of IRF patients when grouped by the discharge diagnosis from their prior hospital stay. Furthermore, diagnosis alone – whether a diagnosis from the prior hospital stay or a post-acute discharge – does not reflect functional status, which is critical to post-acute placement decisions. For example, an alternative approach that makes an apples-to-apples-comparison across post-acute settings is the Uniform Data System for Medical Rehabilitation (UDSMR)[1] two-year stroke study that compares IRF and SNF outcomes. To identify comparable stroke patients, the study selects similar patients based on their prior hospital diagnosis *paired with* data from a functional assessment by the discharging hospital that includes physical and cognitive items, and SNF and IRF outcomes data. The compilation of these data elements is needed to achieve a meaningful apples-to-apples comparison of similar IRF and SNF patients.

We also urge MedPAC to incorporate robust risk adjustment into any discussion of IRF-SNF site-neutral payment policy. Comprehensive risk adjustment will be the critical element of a site-neutral payment policy. For example, the March presentation of 30-day readmission rates for IRFs and SNFs for the three targeted conditions should have been risk adjusted.

In addition, as discussed by MedPAC commissioners, we encourage further comparative research on IRF and SNF readmission rates using multiple episode lengths, including 60- and 90-day episodes, to ensure that the longer SNF average

[1] UDSMR is an independent repository of IRF patient assessment data and rehabilitation outcomes.

lengths of stay are captured. Per MedPAC[2], one-third of SNF stays exceed 30 days in length. Readmissions patterns for this material portion of SNF stays are not included in MedPAC's 30-day readmissions data, which can be corrected by adding readmissions analyses for longer episodes.

SITE-NEUTRAL PAYMENTS SHOULD NOT APPLY TO 60% RULE COMPLIANT CASES

We urge MedPAC to apply IRF-SNF site-neutral payment policy development efforts only to conditions that fall outside of the "60% Rule" and that are also frequently treated in SNFs, such as lower-acuity joint replacement cases.[3] MedPAC should not consider IRF-SNF site-neutral payment policies in isolation from the IRF 60% Rule. Rather, MedPAC should factor in the intent of the 60% Rule when selecting cases to consider for site-neutral treatment. Through the 60% Rule, Congress and CMS have directed IRFs to concentrate their services on 13 clinical conditions. As such, it would be incongruous to reimburse cases with 60% Rule qualifying conditions – such as stroke cases – with SNF-level payments.

MedPAC estimated that industry-wide, in 2013, 60.8 percent[4] of IRF prospective payment system cases had a qualifying condition. Yet, compliance with the 60% Rule – a facility requirement that each IRF must meet to maintain the IRF payment classification – will become more difficult in 2014. Specifically, in October 2014, new CMS guidance will take effect that reduces by 20 percent the number of ICD-9-CM codes that qualify toward 60% Rule compliance. Applying CMS's narrower set of qualifying codes to UDSMR's fiscal year 2013 IRF patient assessment data[5] indicates that IRF facility compliance with the 60% Rule presumptive test[6] would drop by 15 to 20 percent (prior to accounting for behavior change by the field). **The uncertainty about the ramifications of the narrower set of 60% Rule qualifying codes and the concurrent transition to ICD-10 codes, provide further reasons why MedPAC should not add more complexity by proposing to co-mingle the site-neutral payment policy concept with the 60% Rule.**

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[2] MedPAC's March 2012 report to Congress, (page. 197).

[3] Only joint replacement cases meeting the following criteria are compliant with the 60% Rule: Patients with a knee or hip-joint replacement, or both, during an acute care hospitalization immediately preceding the inpatient rehabilitation stay that also meet one or more of the following specific criteria: 1) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute care hospital admission immediately preceding the IRF admission; 2) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF; or 3) The patient is age 85 or older at the time of admission to the IRF. Joint replacement cases may also comply with the 60% Rule if the patient has a qualifying comorbidity.

[4] MedPAC's March 2014 report to Congress (p. 249) estimates IRF 60% Rule case compliance based on January 2013 to July 2013 data from eRehabData.

[5] The UDSMR database contains IRF patient assessment instrument data for greater than 800 IRFs.

[6] IRFs that fail to meet the 60% Rule presumptive test must them demonstrate 60% Rule compliance through a chart audit of a random sample of medical records.

STROKE POPULATION IS UNSUITABLE FOR SITE-NEUTRAL PAYMENT

As suggested during the MedPAC commissioners' discussion, the AHA urges MedPAC to eliminate stroke patients from any IRF-SNF site-neutral payment policy at this time. IRFs provide hospital-level care led by physicians, while SNFs provide a less-intensive set of recuperative services that is, on a day-to-day basis, typically provided by nurses, therapists and lower-level aides. The stroke populations treated in both settings are illustrative of the differences between each setting's level of clinical service and each setting's patient mix. MedPAC's March presentation provided several data points demonstrating the higher acuity levels of the stroke patients treated in IRFs, including a higher overall hierarchical condition category risk score, greater ancillary costs and greater prevalence of comorbidities. These gaps between IRF and SNF stroke patients were notably wider than for the other two targeted conditions (joint replacement and hip/femur fractures).

IRF REGULATORY RELIEF MUST APPLY TO SITE-NEUTRAL CASES

The AHA agrees with MedPAC that a level regulatory playing field is an essential component of any future site-neutral payment policy for IRF and SNF cases. Current Medicare statute and regulations require IRFs to provide hospital-level care, and, therefore, they must be paid hospital-level rates. If in the future, IRF and SNF rates for targeted conditions are made on a site-neutral basis, then the service and regulatory expectations for the site-neutral cases treated in IRFs should be lowered. Likewise, such requirements for SNFs should be raised as needed to achieve apples-to-apples parity for site-neutral cases. Regulatory relief for IRF cases receiving site-neutral payment should include: elimination of the three-hour rule, elimination of the 60% Rule, and elimination of other requirements related to providing hospital-level care, such as maintaining physician and nursing levels on par with hospitals.

We appreciate your consideration of these concerns. IRF-SNF site-neutral payment warrants further exploration by MedPAC, but it should proceed with great caution given the challenge of identifying truly similar patients in both settings. If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development

Cc: Mark Miller, Ph.D.
MedPAC Commissioners